

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**

**Petitioner**

**v**

**File No. 122117-001**

**Blue Cross Blue Shield of Michigan**  
**Respondent**

---

**Issued and entered**  
**this \_15th\_\_\_ day of November 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On June 29, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on July 7, 2011.

The Commissioner immediately notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information it used to make its final adverse determination.

The issue in this external review can be decided by a contractual analysis. The contract is BCBSM's *Community Blue Group Benefits Certificate* (the certificate), which defines the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

**II. FACTUAL BACKGROUND**

On August 7, 2010, the Petitioner was in an automobile accident where he sustained an injury to his jaw (bilateral mandibular fractures). He had surgery the next day. After a period of healing, he saw an orthodontist in November and December 2010 who recommended orthodontic therapy to correct a malocclusion caused by the accident.

The accident occurred while the Petitioner had health care coverage from Medical Mutual of Ohio. On September 1, 2010, his coverage with BCBSM was effective.

BCBSM denied coverage for the orthodontic care. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination dated June 3, 2011, upholding the denial.

### **III. ISSUE**

Is BCBSM required to cover the Petitioner's orthodontic care?

### **IV. ANALYSIS**

The certificate primarily covers medical services. Dental care is only covered in very limited circumstances, such as emergency dental treatment following an accidental injury. In "Section 5: Coverage for Other Health Care Services," the certificate states (p. 5.1):

#### **Dental Care and Dental Appliances**

##### Emergency Dental Treatment

We pay our approved amount for treatment of accidental injuries. An accidental injury is defined as occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

We pay for emergency treatment within 24 hours of the accidental injury to relieve pain and discomfort.

You must complete follow-up treatment within six months of the accidental injury.

In its final adverse determination of June 3, 2011, BCBSM advised the Petitioner's authorized representative its reasons for denying coverage for the orthodontic therapy:

We are unable to authorize the proposed orthodontic services under your medical-surgical benefits because they do not meet the criteria for payment.

\* \* \*

Our guidelines for procedures billed under the medical-surgical coverage also require that coverage has been continuous since the date of the accidental injury.

Your husband's injury occurred in August 2010. He was not covered under your BCBSM plan until September 1, 2010. Therefore, he has not had continuous coverage since the date of his accident. In addition, the six month completion period for follow-up treatment ended in February 2011.

In regard to your other concerns, our records indicate that on March 22, 2011, we received a letter from Dr. XXXXX dated January 8, 2011 along with an Orthodontics Statement indicating Comprehensive Adult Treatment and a charge of \$4,900,00. We reviewed that information and responded to you in a letter dated April 1, 2011. As you and I discussed on the telephone, BCBSM has 35 days to respond to written appeals.

BCBSM's first argument is that the Petitioner did not have "continuous" coverage with BCBSM since the date of the accident. BCBSM's basis for this assertion is found in a document called "Guide for Dental Care Providers" dated January 2005. In a section entitled "Coverage guidelines for procedures billable under the medical-surgical benefit," it states:

The medical-surgical benefit may cover the following accidental dental services:

- Services routinely covered under the Traditional Dental plan
- Emergency care
- Treatment to restore or repair accident related damaged or broken sound natural teeth, previously restored natural teeth and supporting dentoalveolar structures while the patient is covered by the plan, and only if coverage by the plan has been continuous since the date of the accidental injury [Underlining added]

The Commissioner rejects this argument. There is nothing in the certificate that states an insured must have had continuous coverage with BCBSM since the date of the accidental injury to have coverage for dental care arising from that injury. The "Guide for Dental Care Providers" does not define the Petitioner's benefits or amend the certificate; it is a manual for providers. Moreover, the guide states: "Nothing in this manual is intended or should be understood to modify the requirements, limitations and/or exclusions in the BCBSM member's contract." The Commissioner concludes, in this case, that there is no continuous coverage requirement in the certificate for dental care arising from an accidental injury that would otherwise be covered.

BCBSM's second argument is that the Petitioner's follow-up dental treatment was not completed within six months of the accidental injury (i.e., by February 7, 2011). The Petitioner's authorized representative indicates that a pre-determination request was sent to BCBSM by XXXXX, DDS, on January 8, 2011, a month before the six month deadline, and the record contains a copy of Dr. XXXXX' letter. Petitioner's authorized representative wrote to BCBSM as part of the internal grievance process:

First, you claim that accidental dental coverage was effective only for six months following the accident. We submitted a predetermination on 1/08/11 through Dr. XXXXX. . . . We waited for two months and did not receive any notification from Blue Cross and then we contacted customer service and was told that a letter

determining that coverage had been denied had been sent in January. We did not receive such a letter. I had called multiple times trying to determine the status of my claim.

So, we had submitted our claim back in January of 2011, five months after the accident. First, we were told that it was not dental but medical, then Master Medical. Our orthodontist was told to send forms, fax forms (then were told they couldn't be faxed), and to call Blue Cross phone numbers that took them to every department but the one that was correct. They were told to send it to dental and I was told to send it to medical. I have spent hours on the phone trying to get the right person and so have they. . . .

The Petitioner impliedly argues that BCBSM's delay prevented him from receiving orthodontic therapy before the six-month period ended.

BCBSM acknowledges receipt of Dr. XXXXX's letter of January 8, 2011, but states in the final adverse determination that it did not receive it until March 22, 2011. BCBSM indicates that it replied to the Petitioner on April 1, 2011, denying coverage for the orthodontic therapy.<sup>1</sup> The record also contains a form entitled "Blue Cross Blue Shield of Michigan Dental Predetermination Plan" submitted to BCBSM by Dr. XXXXX and dated March 9, 2011, beyond the six months allowed for treatment.

There is no dispute that the orthodontic therapy was not completed within six months of the date of the accidental injury. The Petitioner argues that attempts were made in advance of the February 7, 2011, deadline to have the treatment approved. BCBSM argues it did not get the authorization request until March 2011, yet the Petitioner's authorized representative indicates she called BCBSM in February 2011 and learned that authorization had already been denied.

This is the kind of dispute that cannot be resolved under the Patient's Right to Independent Review Act (PRIRA). The PRIRA process lacks the hearing procedures necessary to make findings of fact based on credibility determinations or evidence such as what was said in telephone conversations. The only undisputed fact is that the follow-up orthodontic care necessitated by the accidental injury was not completed within six months or by February 7, 2011. On that basis alone, the Commissioner upholds BCBSM's final adverse determination.

## **V. ORDER**

Blue Cross Blue Shield of Michigan's final adverse determination of June 3, 2011, is upheld. BCBSM is not required to pre-authorize and cover Petitioner's proposed orthodontic treatment.

---

<sup>1</sup> BCBSM's reason for denying coverage in the April 1, 2011, letter was based on medical necessity.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

---

R. Kevin Clinton  
Commissioner